NAVIGATING YOUR STATE HEALTH BENEFIT PLAN

New Enrollee Decision Guide 2011

PLAN YEAR
JANUARY 1 – DECEMBER 31, 2011

Georgia Department of Community Health

Phone Numbers/Contact Information

State Health Benefit Plan (SHBP): www.dch.georgia.gov/shbp

Vendor	Member Services	Website
CIGNA HRA, HDHP hours 24 hours 7 days a week	800-633-8519 TDD 800-576-1314	www.mycigna.com/shbp
UnitedHealthcare Definity HRA HDHP hours 8 am – 8 pm local time zone; Monday-Friday, TTY 711	800-396-6515 877-246-4189 TDD 800-255-0056	www.welcometouhc.com/shbp
SHBP Eligibility	404-656-6322 800-610-1863	www.dch.georgia.gov/shbp

Disclaimer: The material in this booklet is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen. Availability of SHBP options may change based on changes in federal or state law.

The Summary Plan Description (SPD) for each Plan option is posted on the Department of Community Health website, www.dch.georgia.gov/shbp. You may print or request a paper copy by calling the Customer Service number on the back of your ID card. Please keep your SPD for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 1990, Atlanta, GA 30301-1990.

Georgia Department of Community Health

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

December 1, 2010

Dear New State Health Benefit Plan Member:

Welcome to the State Health Benefit Plan (SHBP). The SHBP is committed to providing high quality health benefits at an affordable price to its members. Upon joining SHBP, new enrollees have the opportunity to choose between two consumer driven health options each offered by CIGNA Healthcare and UnitedHealthcare (UHC). The High Deductible Health Plan (HDHP) and the Health Reimbursement Arrangement (HRA) offered by both vendors provide health care consumers with low monthly premiums, extensive provider networks, and 100 percent unlimited coverage for wellness care based on national age and gender guidelines.

If you choose to take advantage of the HRA, you will have the extra benefit of the SHBP contributing dollars to your HRA on an annual basis for treatment of medical and pharmacy expenses. In 2011, this amount is: $500 for a "You only" plan, $1,000 for a "You + spouse", $1,000 for "You + child (ren) and $1,500 for a "You + Family" which includes you, your spouse and your child (ren).

HDHP has the lowest monthly premium and it allows members to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses which offsets the higher deductible.

Each plan's design is similar to that of a Preferred Provider Organization Plan (PPO) with in-network and out-of-network benefits, wellness benefits, and other enhanced benefits exclusive to the HRA and HDHP plans.

You can access information about these options at www.dch.georgia.gov/shbp.

The Georgia Department of Community Health, which administers the SHBP, is committed to providing you with meaningful choices in your options while keeping costs down. Be assured that we will continue to seek to provide you with meaningful options, low premiums and tools to help you make the right healthcare choices for you and your family members.

Sincerely,

Clyde L. Reese, III, Esq.
Commissioner

Equal Opportunity Employer

Table of Contents

>> SECTION 1 - General Information

This guide will provide you with a brief explanation of each Plan option.

While CIGNA and UnitedHealthcare's basic plan design is the same for each option, each vendor has nuances in benefits and services that are unique to each option. It is important that you read the Decision Guide so you will understand what these differences are and how they may affect you.

State Health Benefit Plan

The Georgia Department of Community Health (DCH), which administers the State Health Benefit Plan (SHBP), continually seeks to offer high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your health care needs, and in turn, must take the time to understand your Plan benefit choices in order to make the best decisions for you and your family.

Let's start by talking about how the SHBP works. It is a self-funded plan, which means that all expenses are paid by employee premiums and employer funds. Approximately 75 percent of the cost is funded by your employer, with you paying approximately 25 percent.

People who do not understand their health coverage pay more, according to the American Medical Association. To help you better understand your Plan and save your health care dollars, we have prepared a few points for you to consider.

What can you do to help manage your health care costs?

Understand Your Options – Compare all Plan Options, considering both the premiums and out-of-pocket costs that you may incur. Web sites and phone numbers are listed on the inside of the front cover of the Decision Guide if you need more information.

Consider Enrolling in a Flexible Spending Account (FSA) – A FSA (also referred to as a health care spending account) helps you save tax dollars, approximately 26–45 percent depending on your tax situation. By electing to use a FSA, you may set aside up to $5,040 annually to cover health-related treatments for yourself and your dependents. Eligible expenses include deductibles, co-insurance and costs for certain procedures not covered under your health plan. The benefit of this account is that you are able to pay for these out-of-pocket costs with tax-free dollars! Contact your Benefit Coordinator for more information.

Become a More Proactive Consumer of Health Care – Most people do not realize how much their treatments, medicines and tests cost.

Steps you can take include:

- Keep a list of all medications you take
- Shop in-network providers and pharmacies
- Find out what your drugstore charges for a drug
- Make sure all procedures are pre-certified, if required
- Make sure you get the results of any test or procedure
- Understand what will happen if you need surgery
- Check your Explanation of Benefits (if provided under your plan option) and if you have questions, ask your provider about it

These and other steps you take will help manage healthcare expenses, reduce your out-of-pocket costs and those of the Plan. In addition, these steps will help in keeping premium costs down.

>> SECTION 2 - SHBP Eligibility Information

All SHBP options have the same eligibility requirements. A summary is listed below.

For You

You are eligible to enroll yourself and your eligible dependents for coverage if you are:

- **A full-time employee of the state of Georgia, the Georgia General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**
  - – You work at least 30 hours a week consistently, and
  - – Your employment is expected to last at least nine months.

  Not eligible: Student employees or seasonal, part-time or short-term employees.
- **A certified public school teacher or library employee** who works half-time or more, but not less than 17.5 hours a week

  Not eligible: Temporary or emergency employees
- **A non-certified service employee of a local school system** who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60 percent of a standard schedule for your position, but not less than 20 hours a week
- **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60 percent of a standard schedule for your position, but not less than 15 hours a week
- **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. See the Summary Plan Description (SPD) for more information
- **An employee in other groups** as defined by law

For Your Dependents

The SHBP covers dependents who meet SHBP guidelines. Eligibility documentation must be submitted and approved before SHBP can send notification of a dependent's coverage to the health care vendors.

Eligible Dependents Are:

1. **Spouse** – Your legally married spouse as defined by Georgia law.
2. **Dependent Child** – An eligible Dependent child of an Enrolled Member must meet one of the following definitions:
   - **Natural or Adopted Child**
     - – **Natural Child**: A child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
     - – **Adopted Child**: Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
   - **Stepchild** – Eligibility begins on the date of marriage to the natural parent and ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which he or she loses status as a stepchild of the Enrolled Member, whichever is earlier.
   - **Legal Guardianship** – A dependent child for whom the Enrolled Member is the legal guardian. Eligibility begins on the date legal guardianship is established and ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier.
   - **Totally Disabled Child** – A natural child, legally adopted child or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the Enrolled Member or is institutionalized, and depends primarily on the Enrolled Member for support and maintenance.

Documentation Confirming Eligibility for Your Spouse or Dependents

SHBP requires documentation concerning eligibility of dependents covered under the plan.

- **Spouse** – Copy of certified marriage license or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The spouse's Social Security Number is also required
- **Natural or adopted child** – 1.) Certified copy of birth certificate listing parents by name (birth card issued by hospital which lists parents by name is acceptable for new births) 2.) For an adopted child – a certified copy of court documents establishing adoption and stating the date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If a certified copy of the birth certificate is not available for an adopted child, other proof of the child's date of birth is required. The Social Security Number is required for all children age two and older
- **Stepchild** – 1.) Copy of certified birth certificate showing your spouse is the natural parent; and 2.) Copy of certified marriage license showing the natural parent is your spouse or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out. The Social Security Number is required for all children age two and older
- **Legal Guardianship** – Certified copy of court documents establishing the legal guardianship and stating the dates on which the guardianship begins and ends and a certified copy of the birth certificate or other proof of the child's date of birth. The Social Security Number is required for all children age two and older

PLEASE READ!

No health claims will be paid until the documentation is received and approved by SHBP.

The member's Social Security Number MUST be written on each document so we can match your dependents to your record. Do not send originals as they will not be returned.

COBRA Rights – Dependents of Active Members

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer your spouse or an eligible dependent the opportunity to continue health coverage if Plan coverage is lost due to a Qualifying Event. The length of time one of your dependents may continue the coverage is based on the Qualifying Event. For further information refer to your SPD. You must make a request to SHBP to continue coverage within 60 days of the qualifying event date that resulted in the loss of coverage.

Making Changes When You Have a Qualifying Event

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, **provided you make the request to SHBP within 31 days of the qualifying event**. Also, your requested change must correspond to the qualifying event. For a complete description of qualifying events, see your SPD. You can contact the Eligibility Unit for assistance at 800-610-1863 or in the Atlanta area at 404-656-6322.

Qualifying events include, but are not limited to:

- Birth or adoption of a child or placement for adoption
- Change in residence by you, your spouse or dependents that results in ineligibility for coverage in your selected option because of location
- Death of a spouse or child, if the only dependent enrolled
- Your spouse's or dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility

IMPORTANT INFORMATION!

- Change requests must be submitted, within 31 days of the qualifying event to SHBP. Requests should not be held waiting on additional information, such as Social Security Number, marriage or birth certificate
- SHBP will accept dependent verification at anytime during the plan year and coverage will be retroactive to the qualifying event date or first of the Plan Year, whichever is later

>> SECTION 3 - Enrolling in the SHBP Coverage

Before You Enroll

You should:

- Read the current *Decision Guide* and SPD to understand your Health Plan Options prior to making your health election
- Contact your employer or payroll location Benefit Coordinator for assistance if you have benefit questions or you may go to www.dch.georgia.gov/shbp
- Read and understand the SHBP Tobacco and Spousal Surcharge Policies on pages 8 and 9, and answer all questions regarding these surcharges. If you fail to answer the questions, the surcharge(s) will apply for the 2011 Plan Year unless you experience a qualifying event or you complete the applicable steps to remove the surcharges as outlined on page 9
- Gather eligibility verification documents for all dependents for whom coverage has been requested to submit within the required time frame
- Understand the election you make will be valid for the 2011 Plan Year unless you experience a qualifying event
- Additional options may be available to you during the Fall Open Enrollment for coverage effective January 1, 2012

Health Benefit Cost Estimators

Choosing the right health plan is an important decision and CIGNA and UHC each provide a Plan Cost Estimator (PCE) tool to assist you. The PCEs offer you a simple way to help determine which option is best for you and your family. These online tools let you compare how your out-of-pocket expenses may vary under the different health plan options available to you.

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures.

How to Enroll

If you're eligible to participate in the SHBP, you become a member by enrolling either:

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll or if you have benefit questions, you may call the vendor directly at the telephone numbers listed on the inside of the front cover of the Decision Guide.
- If you decline coverage under SHBP when you first become eligible and later decide to enroll due to a qualifying event or at a future Open Enrollment period, your options will be limited to the HRA and HDHP for your first Plan year of coverage.
- As a result of a qualifying event. *See Making Changes When You Have a Qualifying Event, page 6 of this guide for more details.*
- If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier (even if there is a gap in coverage) provided you are eligible for that option and have not had a qualifying event since coverage ended.
- If the termination is in one year and you are hired in the following year with a gap in coverage,you are restricted to the consumer driven health plan options: the Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP) with the new employer.

If you decide to become a SHBP member, you will have two major choices to make:

1. Your coverage options:

CIGNA Healthcare

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)*

UnitedHealthcare

- Health Reimbursement Arrangement (HRA)
- High Deductible Health Plan (HDHP)*

* *These options allow you to set up a Health Savings Account. See page 11 for more information.*

2. Which eligible dependents would you like to have covered by SHBP? *For a list of eligible dependents, refer to pages 4 and 5.*

- SHBP is now required to obtain the Social Security Number of each covered dependent

3. Which coverage tier? Select the coverage tier you desire for the dependents that you choose to cover. You will be locked into the tier for the 2011 Plan Year unless you experience a qualifying event.

   - You
   - You+ Child(ren)
   - You + Spouse
   - You + Family*

   **You+ Family = You + Spouse + Child(ren)*

***NOTE:** Additional options may be available to you during the Fall Open Enrollment period for the following plan year.*

What Happens if I Have Other Insurance?

You or your covered dependents may have medical coverage under more than one plan. In this case, coordination of benefits (COB) provisions apply.

When you have other group or Medicare coverage and SHBP coverage, the benefit under SHBP will be no greater than it would have been if there was no coverage other than that of SHBP. Non-covered services or items, penalties and amounts balance billed are not part of the allowed amount and are the member's responsibility.

It is important that you notify the health insurance vendor you selected if you have other group coverage to prevent incorrect processing of any claims. For further information about COB rules, refer to the SPD or contact your health care vendor directly.

What if I Am Working and Am Eligible for Medicare?

Federal Law requires SHBP to pay primary benefits for active employees and their dependents. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty if your plan is creditable. Remember the HDHP plan is NOT creditable. To avoid the penalty, you should enroll in a creditable plan at Open Enrollment if someone under your coverage will turn 65 during the plan year and they will not be enrolling in Medicare due to your active employment.

PLEASE READ!

- Dual coverage (more commonly referred to as State on State coverage) is when two members are eligible for coverage both as an employee and spouse under SHBP. For example: a member is eligible for SHBP coverage through his/her employment and his/her spouse is also eligible for SHBP coverage as an employee.
- If both members are eligible for coverage as employees, it may not be cost effective to cover each other as dependents. This is because regardless of the other coverage (SHBP or another group policy) you will still be responsible for co-payments, deductibles and non-covered or ineligible charges.

Surcharge Policy

You should be aware that SHBP charges a Tobacco and Spousal Surcharge. A $80 tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous 12 months. A $50 spousal surcharge will be added to your monthly premium if you have elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

You will automatically be charged the applicable surcharges if you fail to answer all questions concerning the surcharges. The surcharges will apply to your premium until the next Plan Year unless you take steps to have the surcharges removed. See next page for details.

How to Remove Surcharges

Tobacco

You may have the tobacco surcharge removed if you contact your health care vendor and follow their instructions. See the inside cover for vendor contact information.

Spousal

SHBP charges a spousal surcharge for SHBP members who cover their spouses. You may have the spousal surcharge removed:

- If your spouse becomes covered by his/her employer's health benefit plan; and
- If you make the request and provide proof within 31 days of the effective date of the other coverage.

Please note the SHBP may audit any member covering a spouse who does not pay the spousal surcharge.

No refund in premiums will be made for previous health deductions that included the surcharge amounts. Additional information is available at www.dch.georgia.gov/shbp or in the 2011 Active Decision Guide.

State Health Benefit Plan Retirement and Medicare

If you want to continue your SHBP health insurance coverage after you retire, you and any dependents you want covered must be enrolled in the coverage at the time you retire (please refer to the Retiree Decision Guide or the SPD for detailed information).

General Medicare Information

Medicare is the country's health care system for individuals at age 65 or those with certain disabilities. Medicare includes Parts A - hospitalization, B - provider services and D - prescription drugs.

State Health Benefits Plan Medicare Policy

SHBP Medicare Policy requires all retirees and spouses eligible for Medicare because of age to enroll in one of the four Medicare Advantage (MA) PPO options offered through CIGNA /Humana Alliance and UnitedHealthcare (UHC) in order to continue to receive the State contribution to the cost of premiums. To enroll in a MA PPO option, you must at least have Medicare Part B coverage.

What if I Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employer. You will need to complete enrollment paperwork with your employer and the appropriate form to have the deduction stopped with the retirement system. The same applies if you are receiving SHBP benefits as a surviving spouse and later begin working in a SHBP benefits eligible position.

When you return to retired status, retiree coverage will only be reinstated after notifying the Plan within 31 days if you have continued to receive your retirement annuity. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

IMPORTANT NOTE

- There is critical information about SHBP options and premiums for retirees in the retiree decision guide.
- The HDHP is not considered a creditable plan.
- If you delay Medicare enrollment because you are still working, there is no penalty for enrolling when you retire unless you are enrolled in the HDHP option. You will be charged a Late Enrollment Penalty (LEP) for Medicare Part D if you don't enroll when first eligible.
- If you have questions about your SHBP options and premiums when you plan to retire, call the SHBP Call Center at 404-656-6322 or 800-610-1863.

>> SECTION 4 - Understanding Your Plan Options

Below you will find a brief description of each option offered. CIGNA and UnitedHealthcare are your healthcare vendors and each offer an HRA and HDHP.

NOTE: If you are enrolling in coverage for the first time or if you have not been covered by SHBP during 2010, your options are limited to the HRA or the HDHP for your first Plan Year. During the next Open Enrollment Period, you may have additional options for the next Plan Year.

IMPORTANT NOTE

If you change options or vendors during the year due to a qualifying event, any amounts applied toward your deductible or out-of-pocket are not transferred to the new option.

Health Reimbursement Arrangement (HRA)

The HRA is a Consumer Driven Health Plan option (CDHP) whose plan design offers you a different approach for managing your health care needs. This plan has a national network with in-network and out-of-network benefits. The SHBP funds dollar credits to your HRA each year to provide first dollar coverage for eligible health care and pharmacy expenses. Unused dollars in your HRA account roll over to the next Plan year if you are still participating in this option, but will be forfeited if you change options during the OE or due to a qualifying event.

Plan Features

- The plan offers unlimited wellness benefits based on national age and gender guidelines when seeing in-network providers only
- HRA dollar credits are part of this option only and can only be used with the HRA option
- The amount in your HRA is used to reduce the deductible and maximum out-of-pocket
- There is not a separate deductible and out-of-pocket maximum for out-of-network expenses
- Out-of-pocket limit includes covered prescription drugs
- After satisfying your deductible, you will pay your co-insurance amount until you reach your out-of-pocket maximum.
- Certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management Programs (DSM) for Diabetes, Asthma and/or Coronary Artery Disease
- If you enroll in this Plan after the 1st of the year, your HRA dollars are pro-rated but the deductibles are not

High Deductible Health Plan (HDHP)

The HDHP option offers in-network and out-of-network benefits and provides access to a network of providers on a statewide and national basis across the United States. This Plan has a low monthly premium, and you must satisfy a high deductible that applies to all health care expenses except preventive care.

If you cover dependents, you must meet the ENTIRE deductible before benefits are payable for any covered member.

You may qualify to start a Health Savings Account (HSA) to set aside tax-free dollars to pay for eligible health care expenses now or in the future. *See the Benefits Comparison chart that starts on page 12 to compare benefits under the HDHP to other Plan options.*

Plan Features

- This option offers 100 percent unlimited wellness benefits based on national age and gender guidelines when seeing an in-network provider
- You must satisfy a separate in-network and out-of-network deductible and out-of-pocket maximum
- You pay co-insurance after meeting the entire deductible for all medical expenses and prescriptions until the out-of-pocket maximum is met
- **This plan is not creditable. That means if you don't sign up for Medicare when you first become eligible; you may be charged a late enrollment penalty for Medicare Part D. See the legal notice for more information**

Health Savings Account (HSA) – Information Only

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with a bank or an independent HSA administrator/custodian.

You may open an HSA if you enroll in the SHBP HDHP and do not have other coverage through: 1) Your spouse's employer's plan 2) Medicare 3) Medicaid; or 4) General Purpose Health Care Spending Account (GPHCSA) or any other non-qualified medical plan.

- You can contribute up to $3,050 single, $6,150 family as long as you are enrolled in the HDHP. These limits are set by federal law. Unused money in your account carries forward to the next Plan year and earns interest
- HSA dollars can be used for eligible health care expenses even if you are no longer enrolled in the HDHP or any SHBP coverage
- HSA dollars can be used to pay for health care expenses (medical, dental, vision, and over-the-counter medications when a doctor states they are medically necessary) that the IRS considers tax-deductible that are NOT covered by any health plan (see IRS Publication 502 at www.irs.gov)
- You can contribute an additional $1,000 if you are 55 or older (see IRS Publication 969 at www.irs.gov)
- 20% Non-qualified distribution excise tax

HRA AND HSA CONSIDERATIONS

	HRA	HSA
Overview	A tax-exempt account that reimburses retirees and dependents for qualified medical expenses. Can be funded by employer only.	A tax-exempt custodial account that exclusively pays for qualified medical expenses of the employee and his or her dependents. Can be funded by retiree, employer or other party.
Who is eligible?	Available to SHBP members enrolled in an HRA. See benefits chart for amounts funded by SHBP.	Available to SHBP members enrolled in an HDHP.
Can I have other general medical insurance coverage and take advantage of this benefit?	Yes.	No.
Who owns the money in these accounts?	SHBP. Money reverts back to SHBP upon loss of SHBP HRA coverage.	The member.
Can these dollars be rolled over each year?	Yes.	Yes.
Is there a monthly service charge?	No.	Check with your HSA administrator.
If I terminate my SHBP coverage or change options...	Unused amounts can be distributed until depleted to pay for HRA claims incurred before termination.	Fund disbursement is not tied to individual's employment. Unused amounts can be distributed tax-free for qualified medical expenses. Subject to income and excise tax for non-qualified expenses.

Benefits Comparison: HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Covered Services				
Deductible/Co-Payments • You • You + Spouse • You + Child(ren) • You + Family	$1,300* $2,250* $2,250* $3,250* **HRA credits will reduce this amount*		$1,500 $3,000 $3,000 $3,000	$3,000 $6,000 $6,000 $6,000
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$3,000* $5,000* $5,000* $7,000* **HRA credits will reduce this amount*		$2,400 $4,100 $4,100 $4,100	$5,300 $9,800 $9,800 $9,800
HRA Credits • You • You + Spouse • You + Child(ren) • You + Family	$500 $1,000 $1,000 $1,500		None	
Physicians' Services	*The Plan Pays*		*The Plan Pays*	
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive health care • Annual gynecological exams(these services are not subject to the deductible)	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
Maternity Care (prenatal, delivery and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Physician Services Furnished in a Hospital • Visits; surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Physicians' Services	*The Plan Pays*		*The Plan Pays*	
Physician Services for Emergency Care Non-emergency use of the emergency room not covered	85% coverage; subject to deductible		90% coverage; subject to in-network deductible	
Outpatient Surgery • When billed as office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery • When billed as outpatient surgery at a facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	*The Plan Pays*		*The Plan Pays*	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well-newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery Hospital/facility	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Emergency Care—Hospital • Treatment of an emergency medical condition or injury • Non-emergency use of the emergency room not covered	85% coverage; subject to deductible		90% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	*The Plan Pays*		*The Plan Pays*	
Non Routine laboratory; X-Rays; Diagnostic Tests; Injections—including medications covered under medical benefits—for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	*The Plan Pays*		*The Plan Pays*	
Mental Health and Substance Abuse Inpatient Facility and Partial Day Hospitalization NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Mental Health and Substance Abuse Outpatient Visits and Intensive Outpatient NOTE: Contact vendor regarding prior authorization	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Dental	*The Plan Pays*		*The Plan Pays*	
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
	NOTE: Notification required for all UHC options.			
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person lifetime maximum benefit. This limit does not apply to the HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Vision	*The Plan Pays*		*The Plan Pays*	
Routine Eye Exam NOTE: Limited to one eye exam every 24 months	100% coverage; not subject to deductible	Eye exam not covered	100% coverage; not subject to deductible	Eye exam not covered
Other Coverage	*The Plan Pays*		*The Plan Pays*	
Hearing Services Routine hearing exam	85% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; not subject to the deductible		90% coverage for routine exam and fitting; subject to deductible. $1,500 hearing aid allowance every 5 years; subject to the deductible	
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition	85% coverage; subject to deductible		90% coverage; subject to in-network deductible	
Urgent Care Services NOTE: All subject to deductible except HMO	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison: HRA – HDHP

Schedule of Benefits for You and Your Dependents for January 1, 2011 –December 31, 2011

	HRA OPTION		HDHP OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	*The Plan Pays*		*The Plan Pays*	
Home Health Care Services NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	85% coverage; up to 120 days per Plan year; subject to deductible	Not covered	90% coverage up to 120 days per Plan Year; subject to deductible	Not covered
Hospice Care NOTE: Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or purchase NOTE: Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Other short term rehabilitative services NOTE: 40 visits per therapy	85% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage; subject to deductible; up to 40 visits per therapy per Plan year (not to exceed a total of 40 visits combined, including any in-network visits)	90% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any out-of-network visits)	60% coverage up to 40 visits per therapy per Plan year; subject to deductible (not to exceed a total of 40 visits combined, including any in-network visits)
Chiropractic Care NOTE: UHC Coverage up to a maximum of 20 visits; CIGNA – up to a maximum of 20 days, per plan year	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Foot Care NOTE: Covered only for neurological or vascular diseases	85% coverage; subject to deductible	60% coverage; subject to deductible	90% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services NOTE: Prior approval required	Contact vendor for coverage details	Contact vendor for coverage details	Contact vendor for coverage details	Contact vendor for coverage details
Pharmacy - You Pay				
Tier 1 Co-payment NOTE: No Tiers in HRA Option	15% generic; 25% brand; subject to deductible	40% generic; 40% brand; subject to deductible*	20% coverage; subject to deductible $10 min./ $100 max.	Not covered
Tier 2 Co-payment Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered
Tier 3 Co-payment Non-Preferred Brand	Not applicable	Not applicable	20% coverage; subject to deductible $10 min./$100 max.	Not covered
Tier 4 Co-payment	Not applicable	Not applicable	Not Applicable	Not applicable

>> SECTION 6 - Health & Wellness

What Can You Do About Your Health?

Take a Personal Health Assessment at least once a year to assist you in learning about potential health risks related to your lifestyle and family history. Each vendor has a health assessment questionnaire available on their website that you can complete. After completing the health assessment you will get a customized report that identifies health risks and provides recommendations on ways to help you reduce health risks and suggestions on how to make better lifestyle choices. *Members who complete the health assessment may be contacted by the vendor's registered nurses or health coaches regarding steps they can take to control or eliminate these risks.* **Participant data is completely confidential and individual results are not shared with your employer or SHBP. Members in the HRA who complete the Health Assessment will earn additional dollar credits.**

Utilize the Preventive Health and Wellness services. One of the best ways to stay healthy is to take advantage of preventive health care. Check with the vendor regarding the plan option you choose to confirm which preventive services are covered. In addition, each vendor offers health coaching and wellness programs such as weight loss, nutrition, and stress management and smoking cessation. Contact the vendors to learn more about the programs they offer or visit their website to view available services.

Engage in the Health Management Services. Each vendor offers assistance with health care services including disease management, case management and behavioral health. Please contact the vendor of choice for additional details on programs offered such as the DSM Program that waives prescription drug co-payments/costs on certain medications for members who have Cardiovascular Disease, Diabetes and/or Asthma and remain compliant with the DSM Program requirements.

Call the Nurse Advice Line. Each vendor has a 24-hour, seven days a week (including holidays) nurse advice line that is available to assist you in making informed decisions about your health. Check with your health plan option for the telephone number.

Good health is priceless. When you live a healthy lifestyle, you can feel better, live easier and save money on health care expenses!

DID YOU KNOW?

- Cardiovascular Disease is the leading cause of death in Georgia
- Diabetes in Georgia is 8% higher than the nation as a whole
- Asthma has been diagnosed in approximately 250,000 children in Georgia between the ages of 0–17 years old
- Certain drug costs are waived for HRA members who actively engage in the Disease State Management (DSM) Programs for Cardiovascular Disease, Diabetes or Asthma

>> SECTION 7 - Legal Notices

About the Following Notices

The notices on the following pages are required by the Center for Medicaid & Medicare Services (CMS) to explain what happens if you retire and buy an individual Medicare Prescription Drug (Part D) Plan. The chart below explains what happens if you buy an individual Medicare Part D Plan.

Your SHBP Option	What happens if you buy an individual Medicare Part D Plan
SHBP Medicare Advantage PPO Standard or SHBP Medicare Advantage PPO Premium Plan	You will permanently lose SHBP coverage if you purchase a Part D Plan once enrolled in a SHBP Medicare Advantage Plan. You will not pay a Medicare "late enrollment" penalty
HRA /HMO	Your Medicare Part D Plan will be primary for your prescription drugs unless you are in the deductible or doughnut hole and then SHBP will provide benefits. If you reach the Out-of-pocket Limit, SHBP will coordinate benefits with your Medicare Part D Plan. You will not pay a Medicare "late enrollment" penalty
HDHP (High Deductible)	You will have to pay a Medicare "late enrollment" penalty if you miss the initial enrollment period because the HDHP option is not considered "creditable coverage"

These notices state that prescription drug coverage under all SHBP coverage options except for the HDHP (High Deductible) option is considered Medicare Part D "creditable coverage." This means generally that the prescription drug coverage under SHBP MA Standard, SHBP MA Premium, HMO and HRA are all "as good or better than" the prescription drug coverage offered through Medicare Part D plans that are sold to individuals.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP about Your HDHP Prescription Drug Coverage and Medicare

About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare High Deductible Health Plan (HDHP) and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three (3) important things you need to know about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the HDHP option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP offered by SHBP. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3 You can keep your current coverage in a CIGNA or UnitedHealthcare HDHP offered by the SHBP. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and costs of the plans offering Medicare Prescription Drug Coverage in your area. *Read this notice carefully as it explains your options.*

When Can you Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage under SHBP, since it is an employer sponsored group plan; you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare Drug Plan; However, you also may pay a higher premium (a penalty) because you did not have Creditable Coverage under SHBP.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When will you pay a Higher Premium (a Penalty) to Join a Medicare Drug Plan?
Since the HDHP coverage under SHBP, is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have coverage. For example, if you go nineteen months without creditable coverage, your premium may be consistently 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens to Your Current Coverage if you Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current HDHP coverage under SHBP will be affected. If you enroll in Medicare Part D when you become eligible for Medicare Part D, you can keep your HDHP coverage and the HDHP will coordinate benefits with the Part D coverage. If you decide to join a Medicare Drug Plan and drop your HDHP coverage under SHBP, be aware that you and your dependents will not be able to get your SHBP coverage back if you are a retiree.

You should also know that if you drop or lose your HDHP coverage with SHBP and don't join a Medicare Drug Plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

For more information about this notice or your current prescription drug coverage...
Contact the SHBP Call Center at (404) 656-6322 or (800) 610-1863 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug coverage, and if this coverage through SHBP changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call (1-877-486-2048). 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at (1-800-772-1213). TTY users should call (1-800-325-0778).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P.O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

Important Notice from the SHBP About Your Prescription Drug Coverage with the CIGNA and UnitedHealthcare HMO, HRA and Medicare

For Plan Year: January 1 – December 31, 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to learn about your current coverage and Medicare's prescription drug coverage:

1 Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2 The SHBP has determined that the prescription drug coverage offered by the CIGNA and UnitedHealthcare HMO and HRA offered under SHBP is, therefore, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Do Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your SHBP coverage will be affected. You can keep your SHBP coverage if you elect Part D and SHBP will coordinate with Part D coverage the month following receipt of enrollment notice. You should send a copy of your Medicare cards to SHBP at P.O. Box 1990, Atlanta, GA 30301.

If you do join a Medicare drug plan and drop your coverage with SHBP, be aware that you and your dependents can not get this coverage back if you are a retiree.

Buying any individual Medicare insurance product outside of the Medicare Advantage plans offered through SHBP could AUTOMATICALLY and PERMANENTLY END your SHBP Coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about this Notice or Your SHBP Current Prescription Drug Coverage…
Contact the SHBP Eligibility Unit at 404-656-6322 or 800-610-1863. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage, through SHBP changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. 24 hours a day/7 days a week

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2010
Name of Entity/Sender: State Health Benefit Plan
Contact: Call Center
Address: P. O. Box 1990, Atlanta, GA 30301
Phone Number: 404-656-6322 or 800-610-1863

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010

State Health Benefit Plan Annual Legal Notices

Women's Health and Cancer Rights Act

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option. Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification. For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover.

Newborns' and Mothers' Health Protection Act

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability and Accountability Act

The Plan complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The HIPAA Privacy Notice is attached as Exhibit A. The Notice of Exemption Letter is attached as Exhibit B.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

Exhibit A

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports. These reports explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan, your employer may also get summary reports.

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. "Enrollment Information" includes: 1) your name, address, and social security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you have. This Enrollment Information is the only kind of PHI your employer is allowed to see. "Claims Information" includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, x-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are "Plan Representatives." They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs but they are never allowed to use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign "Business Associate" agreements with the Plan. Here are some examples what they do.

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra help to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply with a Law, or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law, or to prevent a serious threat.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For example, the Plan may give PHI to DCH employees in the Public Health Division who need it to do their jobs.

For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you, and with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member. You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the authorization later by writing to the contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April, 2003.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you in a special way.

Right to a Paper Copy of this Notice, Right to File a Complaint Without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:

SHBP HIPAA Privacy Unit
P.O. Box 1990, Atlanta, Georgia 30301 404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

U.S. Department of Health & Human Services, Office for Civil Rights
Region IV Atlanta Federal Center 61 Forsyth Street SW, Suite 3B70 Atlanta, GA 30303-8909

Georgia Department of Community Health

Two Peachtree Street
Atlanta, GA 30303
(404) 656-6322 • (800) 610-1863

October 1, 2010
Exhibit B

Election to be Exempt from Certain Requirements of HIPAA

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

The Department of Health and Human Services considers tobacco use to be a health status-related factor. Therefore, the Department of Community Health will exempt the SHBP from the following requirement in order to apply the tobacco surcharge.

> Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors.

The Department of Community Health will exempt the SHBP from the following requirement in order to apply a 31 day period for making any enrollment change as a result of a qualifying event.

> Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also, if a plan provides dependent coverage, the plan must provide a special enrollment period for new dependents (and the employee if not already enrolled) within 30 days after a marriage, birth, adoption or placement for adoption. A 60-day special enrollment period applies to eligible individuals who lose eligibility for Medicaid coverage or coverage under a State child health plan, or becomes eligible under Medicaid or a State child health plan for group health plan premium assistance.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act are effective January 1, 2011 unless the Department of Community Health elects to be exempted from this law's requirements. The temporary rules have generated over 4,000 comments, and the claims administrators of the State Health Benefit Plan are still in the process of developing and testing procedures that comply with the temporary rules. The federal agencies that wrote the temporary rules have stated that they are currently reviewing the 4,000 comments, and will address those comments and provide clarification in final rules. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2011 calendar year.

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2011 and ending December 31, 2011. The election may be renewed for subsequent plan years.

HIPAA also requires the SHBP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the SHBP. There is no exemption from this requirement. The certificate provides evidence that you were covered under the SHBP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Common Acronyms

CDHP – Consumer Driven Health Plan

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of Benefits

DCH – Georgia Department of Community Health

FSA – Flexible Spending Account

HDHP – High Deductible Health Plan

HMO – Health Maintenance Organization

HRA – Health Reimbursement Arrangement

HSA – Health Savings Account

IRS – Internal Revenue Service

MA (PPO) – Medicare Advantage Preferred Provider Organization

OE – Open Enrollment

PCF – Personalized Change Form

PCP – Primary Care Physician

ROCP – Retiree Option Change Period

SHBP – State Health Benefit Plan

SPC – Specialist

SPD – Summary Plan Description

UHC – UnitedHealthcare

Georgia Department of
Community Health